STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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CITATION
42 CFR 413.30 and 413.40

Inpatient hospital services (other than those provided in an institution for Tuberculosis or mental disease) are reimbursed as follows:

I. Reimbursement Methodology

Medicaid uses the Medicare (Title XVIII) principles of reimbursement in accordance with HIM 15 requirements as a guide to determine Medicaid (Title XIX) reimbursement.

A. **Methods of Payment for Cost Reporting Periods Beginning on or After October 1, 1982. This methodology applies to non-state operated hospitals only through dates of service June 30, 1994. This methodology continues to apply to State-operated hospitals beyond June 30, 1994.**

For all hospitals participating as a Title XVIII/XIX provider, the State agency shall apply:

1. Title XVIII (Medicare) Standards for reporting.

2. Title XVIII (Medicare) cost reporting periods for the ceiling on the rate of increase in operating costs under 42 CFR 413.40 The base year cost reporting period to be used in determining the target rate shall be the hospital's fiscal year ending on or after September 30, 1982.

3. Title XVIII reimbursement principles as set forth in 42 CFR 413.40 except that costs for Neonatal and Pediatric Intensive Care (NICU/PICU), Burn Unit and organ transplant services shall be carved out and reimbursed as specified below in I.A.4.b.(4-5). The target rate limitation determined shall be applied to all applicable hospital cost reporting periods beginning on or after October 1, 1982.

   The limitation on reasonable costs established under 42 CFR 413.30 shall not be applied for cost reporting periods subject to the target rate limitation.

4. Vendor payment for inpatient hospital care will be made in accordance with ~~the following~~ reimbursement methodology:

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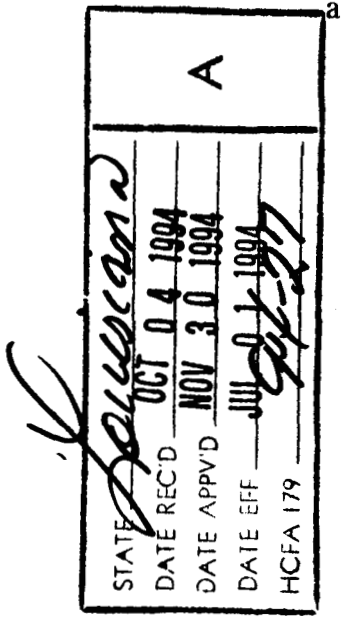
Effective for cost reporting periods beginning on or after October 1, 1982, each hospital shall have a target rate set based on cost per discharge. This rate shall be determined using the hospital's cost report data for the fiscal year ending in the base period of either September 30, 1981 through September 29, 1982 or September 30, 1982, through September 29, 1983. Data from the twelve month cost reporting period of the base year shall be extracted to determine each hospital's cost per discharge.

NICU/PICU/Burn Unit costs shall be carved out prior to calculation of the target rate. For hospitals with a cost reporting period of less than twelve months in the base period, the same full 12 month cost reporting period designated by Medicare as the base period shall be used in calculating the Medicaid target rate or, if none, the next full twelve month period after the 82-83 base period.



a. Operating costs to be <u>included</u> in determining the base year's cost per discharge are as follows;

(1) Routine operating costs, such as room/board and routine nursing services, except for such costs for NICU/PICU/ Burn/Transplant Units which are excluded as noted in I.A.4.b.(4-5) below.

(2) Ancillary service operating costs, such as the operating costs of radiology and laboratory departments; except for ancillary costs associated with an NICU/PICU/Transplant stay which are excluded from the target rate as specified in I.A.4.b.(5) below.

Cost per discharge shall be calculated by totalling the Medicaid allowable costs noted above, and dividing by the number of Medicaid discharges for the cost reporting base period.

b. Operating costs specifically <u>excluded</u> from the calculation of cost per discharge are the following:

(1) Capital related costs, such as depreciation;

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(2) Malpractice insurance cost and

(3) Education costs, such as cost of approved medical and nursing education programs that are allocated to approved intern and resident programs and nursing school cost centers in the cost reports.

(4) For cost reporting periods beginning October 1, 1982, and thereafter, specialized intensive care unit costs, specifically neonatal and pediatric intensive care unit (NICU/PICU) Burn Unit and transplant services costs which are cost settled on or after July 1, 1984, shall have the routine operating costs (room/board/and nursing care) carved out and reimbursed separately from the target rate limitation. A per diem limitation for days in these units shall be calculated based on the costs and days for these units specified in the base period noted in I.A.4.a. above. This base per diem rate shall then be inflated by the applicable target rate percentage as defined in I.A.4.c. below.

Reimbursement for these services is limited to the lesser of costs or the per diem rate times those days determined to be medically necessary. No incentive or penalty payment will be allowed for reimbursement for these carve-out unit costs.

For subsequent years, this per diem rate shall be inflated by the target rate percentage as defined in I.A.4.c. below.

Ancillary charges related to stays in these carve-out units shall be included in the overall target rate limitation.

(5) For cost reporting periods beginning October 1, 1984 and thereafter, Neonatal and Pediatric Intensive Care Unit (NICU/PICU) and Transplant services costs to be carved out shall include both the routine operating costs (room/board and nursing care) and the ancillary costs

associated with an NICU/PICU/Transplant stay. These costs shall be passed through and reimbursed 100% of allowable costs as defined by Medicare principles of reimbursement. Discharges applicable to these carve-out units shall be carved out of total Medicaid discharges prior to calculation of the target rate limitation.

Burn unit costs shall continue to be reimbursed as noted in I.A.4.b.(4) above. Burn unit discharges shall be included in the total Medicaid discharges for the calculation of the target rate limitation.

(6) For cost reporting periods beginning October 1, 1985, reimbursement for carve-out unit (NICU/PICU/Burn/ Transplant) costs noted above shall be limited in accordance with a per diem limitation established for discharges reflecting carve-out unit services. The per diem limitation shall be calculated based on costs (routine and ancillary) for such carve-out discharges derived from each hospital's first cost reporting period under the TEFRA (Tax Equity and Fiscal Responsibility Act) cost per discharge limitation (fiscal years ending September 30, 1983 through August 31, 1984). The base period per diem costs for care-out units shall be trended forward using the target rate percentage for hospital inpatient operating costs established by the Health Care Financing Administration (HCFA). For subsequent fiscal years, the limitation shall be inflated by the applicable target rate percentage. Discharges applicable to these carve-out units shall be deleted from the total Medicaid discharges prior to calculation of the target rate limitation. Reimbursement for carve-out unit services shall not exceed the per diem limitation and no incentive payment shall be allowed.

The provisions for exceptions and adjustments cited at I.A.4.f. shall also apply to the per diem limitation for carve-out unit reimbursement.

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(7) For services provided on or after July 1, 1991 to infants under one year of age, cost limits (per discharge or per diem limits) shall not be applied. If an infant remains an inpatient on his first birthday, the nonapplication of the cost limits shall continue until such infant is discharged.

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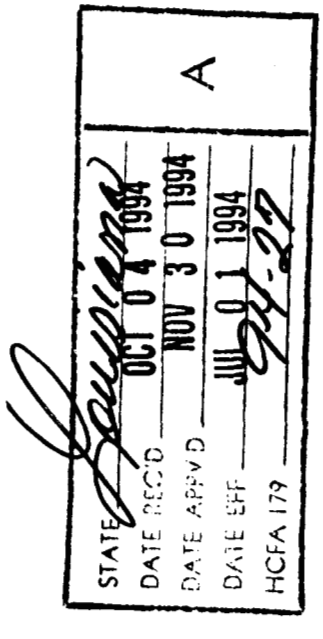
(4) For cost reporting periods beginning July 1, 1987, the target rate percentage is that prospectively determined percentage published by the Health Care Financing Administration applicable to Non-Prospective Payment System hospitals. This percentage is based on the estimated increase in the market basket index for the calendar year, adjusted by other factors as determined by the Secretary of Health and Human Services. this percentage shall be applicable to both the cost per discharge limitation and the carve-out unit per diem limitation.

The target rate for subsequent years shall be determined by increasing the previous year's target rate by the appropriate target rate percentage as defined above, for the applicable cost reporting periods.

d. Application of the Target Rate

Application of the Target Rate in determining reimbursement payment made under the rate of increase ceiling or operating costs will take into account beneficiaries' deductible and co-insurance obligations under Section 1813 of the Social Security Act, but without regard to Section 1814(b) which requires payment to be made on the basis of charges when they are lower than reasonable costs.



After each affected cost reporting period, the Medicaid audit intermediary will compare a hospitals actual allowable inpatient operating cost per discharge to its target amount.

(1) For cost reporting periods beginning October 1, 1982, if a hospital's actual operating cost per discharge is less than its target rate, it shall be reimbursed its allowable cost per discharge plus fifty (50%) per cent of the difference between its actual cost per discharge and its target rate, up to five (5%) per cent of the target rate.

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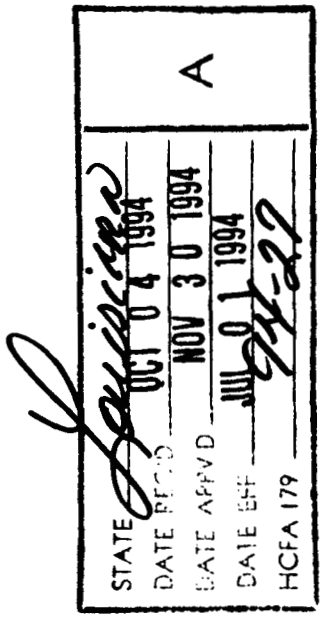
For cost reporting periods beginning August 1, 1985, if a hospital's actual operating cost per discharge is less than its target rate, it shall be reimbursed only its allowable costs as no incentive payments shall be made.

(2) For cost reporting periods beginning October 1, 1982, if a hospital's actual operating cost per discharge is greater than its target rate, it shall be reimbursed its target rate plus twenty-five (25%) per cent of allowable operating costs per discharge in excess of the target rate.

For cost reporting periods beginning October 1, 1984, if a hospital's actual operating cost per discharge is greater than its target rate, reimbursement shall be limited to the target rate with no payment for costs in excess of the target rate.

Reimbursement for those costs not included in the cost per discharge as noted in A.4.b. above shall be added to the reimbursement for discharges to determine the hospital's total Medicaid reimbursement.



A hospital may request an exemption or exception to the rate of increase ceiling as noted below. Requests must be submitted to the Director, Bureau of Health Services Financing (BHSF), within sixty (60) days from the date on the Bureau's notice of program reimbursement. The fiscal intermediary will make a recommendation on the hospital's request to the Bureau of Health Services Financing which will make a decision.

The BHSF will respond to the request within sixty (60) days from the date the appeal is received by the Director. If an exemption or exception is granted a hospital by Title XVIII, an exemption or exception shall be granted for Medicaid (Title XIX) reimbursement.

e. Exemptions

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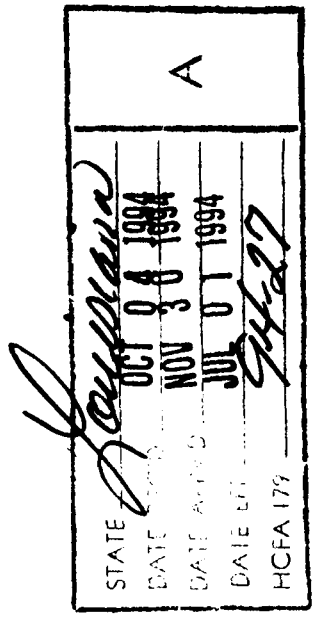
(1) New hospitals shall be exempt from the rate of increase ceiling. A new hospital is defined as a provider of inpatient hospital services that has operated as the type of provider which is certified for Medicare and/or Medicaid participation, under present and previous ownership, for less than three (3) full years. This exemption expires at the end of the first cost reporting period beginning at least two (2) years after the hospital accepts its first patient.

In addition, hospitals enrolled as emergency access only providers prior to September 1, 1983, which subsequently enroll as full access providers, shall be considered new hospitals until completion of their first twelve (12) month cost reporting period under Medicaid.



(2) Risk-basis health maintenance organizations (HMO's) shall be exempt from the rate of increase ceiling. This includes items or services which are furnished to beneficiaries enrolled in an HMO by a hospital that is either owned or operated by a risk-basis HMO or related to a risk-basis HMO by a common ownership or control.

(3) Hospitals exempt from the rate of increase ceiling shall be reimbursed in accordance with the standards and principles described in 42 CFR 405.402 - 405.455 (excluding, effective July 1, 1969, the inpatient routine nursing salary cost differential under the Medical Assistance Program).

f. Exceptions

A hospital may request to have its operating costs per discharge (as described in A.4.a. above) adjusted upward or downward, in the base period or subject period.

An adjustment shall be calculated only to the extent that the hospital's operating costs are reasonable, attributable to the

circumstance specified, and separately identified by the hospital and verified by audit.

The two types of exceptions for which adjustment may be requested are as follows:

(1) Extraordinary circumstances - the hospital can demonstrate that it incurred unusual costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, floods or similar unusual occurrences with substantial cost effects.

(2) Change in Services (Case Mix) - the hospital has added or discontinued services in a year after its base period described in A.4.a. above, which results in a significant change in its cost per discharge.

g. Adjustments

When necessary to maintain comparability of costs between cost reporting periods, an adjustment may be made to the inpatient operating costs in either the base period or a period that is subject to the rate of increase ceiling to take into account factors such as a decrease in inpatient hospital services that would distort the comparison of costs per discharge between cost reporting periods. Examples of situations with such effects include closing a special care unit or changing the arrangements under which a particular service is furnished, such as leasing a department. In these and other cases, the amount of inpatient operating costs considered in establishing cost per discharge shall be adjusted to maintain comparability of costs between periods.

An adjustment may also be calculated to protect against the possibility of abuse, in instances where unwarranted increase in or other manipulation of discharges is undertaken by hospitals for the purpose of increasing reimbursement.